The Kentucky Foster Care Census: Measuring Child Well-Being in the Child Welfare System

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Research Problem

Concern about the overall well-being of children is increasingly becoming more of a priority in social work (Andrews & Ben-Arieh, 1999). Historically, social workers in the field of child welfare, the area responsible for working with maltreated children, have focused primarily on keeping those children safe from abuse and neglect. Presently, it has been realized that these foci are too narrow in scope, and should instead include more comprehensive aspects of child well-being, beyond safety and permanency.

The three goals of the Adoption and Safe Families Act, passed in 1997 containing mandates for public child welfare agencies, are safety, permanency, and improving the well-being of children and families (PL 105-89). This is the first time that well-being has been made a specific goal. There has been a lack of focus on the well-being of children in the child welfare system. Altshuler and Gleeson (1999) described the foci on safety and permanency, to the exclusion of well-being, as a triangle that can only be completed when well-being becomes a focus of child welfare services.

Research Background and Questions

As of 1998, there were still no federal well-being outcomes (DHHS, 1998). However, with the publishing of the Administration of Children and Families Final Rule of 2000, the child well-being outcomes were established and they are as follows: (a) Families have enhanced capacity to provide for their children's needs, (b) Children receive appropriate services to meet their educational needs, and (c) Children receive adequate services to meet their physical and mental health needs (DHHS, 2000). These outcomes were developed after those for safety and permanency.

Based on the mandate to measure child well-being for federal accountability in child welfare, the decision to use a census approach for measuring well-being in Kentucky, and the data that were collected from this study, the questions for this research are as follows:

I. What is known about child well-being from the literature?

II. How does the data from the C*hild Census Forms* of the Kentucky Foster Care Census inform us about the well-being of the children in foster care in Kentucky?

III. Based on the exploration of the census data, what is the relationship between the well-being indicators and the provision of the appropriate services for a child's diagnosed need(s)?

IV. Based on the exploration of the census data, what is the relationship between the well-being indicators and the level of involvement with the child in their own case decision-making?

Methodology

This dissertation utilized census data, studying the entire population of children in the Cabinet for Families and Children foster care in the state of Kentucky. This was a pre-experimental design, an exploratory study of child well-being indicators. The data were collected in 1338 foster/adoptive homes by 131 census takers from across the state, which mainly consisted of Bachelor and Master's level social work students from eight Kentucky universities (Huebner, Wolford, & Hommrich, 2002; TRC, 2002).

Variables

There were several different independent, or predictor, variables for this study. These included gender, type of care (foster or adoptive), the existence of an Individual Educational Plan for the child, who attends meetings and signs documents for the child at school, being placed as a part of a biological sibling group, whether or not the siblings placed were placed together, and the geographical location of the child (urban or rural). Also, age, length of time spent in current out-of-home care placement, length of time since the last physical and dental health visits to providers, the number of prior placements in out-of-home care, the length of time since last visitation with the biological family and biological siblings, and the length of time since the last visit with the child by the Department for Community-Based Services (DCBS) caseworker were measured. In addition, the rating of importance of visits with the biological family, the satisfaction of the foster parents with the visits of the DCBS worker, and the rating of the importance of the child visiting with their biological family were also independent variables.

The dependent variables in this study consisted of questions asked in the domains of medical, emotional, educational, and physical/developmental delay needs, asking if the child had identified or diagnosed needs in these specific areas and if those needs were being met adequately. These dependent variables were all gathered at the nominal, or categorical, level. The foster parent or regional staff that completed the form were instructed to answer "yes" or "no" to both questions (is there a diagnosed need and is the need being met adequately?). A final dependent variable was an ordinal-level rating of the child's decision-making involvement with DCBS staff/workers in their own case

about the child's own care that was completed by the foster parent. This was measured on a four-point Likert-scale, ranging from rarely or never to consistently.

Results

Descriptive statistics on all of the variables were run in order to get a statistical picture of the well-being of children in foster care in Kentucky. Due to this research utilizing a census approach that was conducted with a large population (the children in foster care in Kentucky), rather than a smaller sample, and since most of the variables were measured at the nominal level, the exploratory technique CHAID (chi-square automatic interaction detection) (Kass, 1980) was used for data analysis. CHAID is typically used to explore group differences of large categorical data sets on different predictor variables, which in this study was the well-being indicators obtained from the KFCC *Child Census Forms* database.

The total population, which was the number of foster children counted in the Kentucky Foster Care Census, was 2996. The data were collected in 100% of the homes and the entire population was counted, ensuring that no child was missing (Huebner, 2003). Just over half of the children were female (53%, $n = 1577$) and a little less than half were male (47%, $n = 1404$). There was a wide range of ages among the children in the sample, with the youngest being infants less than one year old ($n = 134$), and the oldest age in the sample being 21 years old. The average age of the children in the sample was 8.3 ($SD = 5.57$). The median age was eight years old and the mode was two years old. There were also differences in the total number of months spent in care by each child. The average total length of time in the foster care system for the children in the sample was 25.14 months ($SD = 27.52$). The average length of time in the current foster or adoptive home was 18.47 months ($SD = 24.32$). However, the mode was one month, which indicated that most of the children in the sample had been in their current placement for a short amount of time. Seventy-four percent ($n = 2208$) of the children in the sample were placed in a rural region of the state, while 26% ($n = 788$) were placed in an urban region of the state. See Table 1 for a summary of the demographics of the study.

Summary of CHAID Analysis Findings by Domain

Table 2 contains a summary of the percentages of the sample that had a diagnosed problem in each of the domains and the percentages that were indicated to be receiving adequate resources in each area. The following section will summarize these results and discuss the implications for practice.

Medical needs

About one-third of the children in this sample were indicated to have a diagnosed medical need. The baseline rate of need was 32%. For diagnosed medical need, the number of total months spent in foster care was the strongest predictor of having a

diagnosed medical need, X_2 (2, n = 2812) = 38.13, p < .001. As time in care increased, so did the likelihood of having a diagnosed medical need.

Number of months in care, number of DCBS visits in the past six months and age were also predictors of diagnosed medical need. Children with at least monthly DCBS visits had a higher percentage of needs. This may indicate that the children with these needs are being identified and that they are getting visited consistently. Younger children had more medical needs. In addition, children who had been to the dentist five months ago or less had a high percentage of needs, which may indicate that children whose medical needs were identified, were also receiving other types of care, such as dental.

The rate of identified medical needs was a little lower for this sample than some of the child welfare literature suggests, which has been as high as 60% (Takayama, Wolfe, & Coulter, 1998), but is very close to some studies citing 30 – 39% of the children in foster care having medical problems (Kortenkamp & Ehrle, 2002). Issues that will affect the children for many years to come need to be identified and proper resources must be identified and accessed as early as possible.

Overall, most of the children in the sample (78%) were judged to be receiving adequate medical help. Geographical region of commitment was the strongest predictor of the adequacy of the medical resources, X_2 (5, n = 2793) = 186.76, p < .001. But, findings on urban and rural regions were mixed. It could be that even though there are resources in the urban areas, the children in foster care do not have access to them in order to get their needs met. Bilaver et al. (1999) found that children served by child welfare agencies tend to get more physical health treatment than do children in the general population.

Emotional needs

Almost half of the children in this sample were indicated to have a diagnosed emotional need (44% was the baseline rate for having this type of diagnosis). The most significant predictor of having an identified emotional need was age, X_2 (6, n = 2797) = 419.91, p < .001. The five to twelve year-old age group was the most likely to have an identified emotional need. This is quite a large age span, both developmentally and chronologically. DCBS workers and foster parents should be aware that this age group is most likely to have an emotional problem and to know that mental health services must be provided for an accurate assessment to be made and for services to begin.

In addition to age, number of months in care also made a difference, as time in care increased, so did the likelihood of having an identified emotional problem. Also, children with more than two prior placements were more likely to have an emotional problem than children with zero or one prior placement. So, as children continue in the system and get older, it is very important to be aware of any emotional needs they may have and to connect them with the appropriate resources for treatment. In addition, boys had a higher percentage of diagnosed emotional need than did girls.

The overall fairly high percentage of emotional need fits with existing literature regarding the mental health of children in foster care (Dos Reis et al., 2002; Farmer et al., 2001; Leslie et al., 2000), which says that foster children are likely to have diagnosed

mental health problems. However, some studies have estimated a higher percentage of need, at 80% (Zima et al., 2000). This sample of foster children also had high percentages of emotional need, perhaps because they have been exposed to violence, and perhaps may be suffering from PTSD due to the abuse (Avery, Massat, & Lundy, 2000; Stein et al., 2001). Overall, most of the children in this sub-sample were judged to be receiving adequate emotional help (78%). Just as the adequacy of the medical resources were affected most by region, so was the adequacy of the emotional resources, X_2 (5, n = 2959) = 134.85, $p < .001$.

Educational needs

About one-third of the children in this sample were indicated to have an identified educational need. The "base rate" for this type of diagnosis was 35%. Having an IEP or not was the strongest predictor of identified educational need, X_2 (1, n = 2793) = 849.78, $p < .001$. Children with an IEP had a higher percentage of educational needs, which indicated that many of them were being identified and services were being provided. For the children who had an IEP, those who were not placed with siblings had a higher percentage of educational needs than those who were placed with siblings. Older children had more needs than did younger children, and the boys were more likely to have educational problems than were the girls. Reyome (1993) also found that maltreated children were at risk for academic failure and had a number of academic problems.

For educational needs, as number of months in care increased and number of prior placements increased, so did the percentage of having an identified educational need. So, it is important that workers continue to be aware of any educational problems a child may be having, to provide educational advocacy, and to arrange for any screening or testing that is required to identify problems, even after they have been in care. It is important to screen and identify problems when coming into care, but being aware of educational needs should continue because children who had been in care longer had more needs.

Overall, most of the children in the sample were judged to be receiving adequate educational resources to meet their needs (80%). Region was again the strongest predictor related to the adequacy of the educational resources and percentage of educational needs being met, X_2 (1, n = 2756) = 137.53, $p < .001$. Zima et al. (2000) found that only about half of the children they studied were receiving adequate educational services that were needed, so this sample seems to be doing better in terms of services received. This sample was closely in line with another study that found that about 29% of foster children do not receive adequate help for their educational needs (Kortenkamp & Ehrle, 2002).

Physical disability

Overall, there were not very many children in this sample who had a diagnosed physical disability. Only 9% were indicated to have a diagnosed physical disability. This number was lower than some of the literature suggests is the prevalence rate of disabilities in the presence of maltreatment (Sullivan & Knutson, 2000).

Number of months in care was the strongest predictor of diagnosed physical disability, X_2 (2, n = 2802) = 29.47, p < .001. As time in care increased, so did the likelihood of having a physical disability. Children who had been in care for about five years or more were the most likely to have a physical disability (16%). Those in care between four months and five years were the next highest rate (10%), while those in care less than four months were not very likely to have a physical disability (5%). Children who averaged more than one DCBS visit per month and that also had been to the doctor in four months or less were more likely to have a physical disability than those with less visits and more time since being at the doctor. This seems to indicate that the workers spent more time with children with this type of need and that these children also went to the doctor more often. Younger children were more likely to have a diagnosed physical disability than were older children.

In terms of receiving adequate therapy for a diagnosed physical disability, region was the most significant predictor, X_2 (5, n = 2794) = 153.85, p < .001. Overall, 70% of the children were receiving adequate help for this need.

Developmental disability

About one-fourth of the children in this sample were indicated to have a diagnosed developmental disability (23%). Having an IEP was the strongest predictor of diagnosed developmental disability, X_2 (2, n = 2797) = 348.80, p < .001. This is the same as it was for having identified educational needs. A higher percentage of yes responses were found for children who had an IEP.

Also, children who had been in care longer had higher percentages of having a diagnosed developmental disability. Younger children (less than age nine) were also more affected by this than were the older children in the sub-sample. Takayama et al. (1998) also found that younger children in foster care were more likely to have developmental delays. Boys also had a higher percentage of diagnosed developmental disability than did the girls.

Overall, about three-fourths of the children in the sample were judged to be receiving adequate support or help for their developmental disability (74%). Region was again the strongest predictor of receiving adequate resources for a developmental disability, X_2 (3, n = 2772) = 161.08, p < .001. This was the same predictor variable for all of the categories relating to the adequacy of the resources.

Level of child's involvement in their own case decision-making

A final dependent variable was the rating of the child's involvement in the decision-making in their own case, or the consistency of how often they are involved in decisions about their care. This question was to be completed by the foster/adoptive parent only. Almost half of the sample, 47%, was judged to be too young or unable to be involved in the decision-making of their own case (n = 1342). The rest of the responses were as follows: 14% were consistently involved (n = 389), 15% were sometimes involved (n = 440), 10% were rarely or never involved (n = 273), and 14% were frequently involved (n = 406).

The most significant predictor was age of the child, X_2 (7, n = 2850) = 1629.26, p < .001. Eight age groups split out and they were as follows: less than two-years old (n = 558, or 20% of this sub-sample), 2 to 5 years old (n = 566, or 20% of this sub-sample), between ages 5 and 7 (n = 277 or 10% of this sub-sample), 7 to 9 years old (n = 272, or 9% of this sub-sample), ages 9 to 11 (n = 255, or 9% of this sub-sample), ages 11 to 14 (n = 390, or 14% of this sub-sample), ages 14 to 16 (n = 276, or 10% of this sub-sample), and over age 16 (n = 256, or 9% of this sub-sample). Not surprisingly, as age increased so did the level of consistency in decision-making in treatment. Children over age 16 were consistently involved in their own case at a rate of 37% (n = 94), while these same children were frequently involved 32% (n = 81) of the time. Only 8% (n = 20) of the children over age 16 were rarely or never involved in their case decision-making. Also, the more involved that DCBS was with the child, and the more visits they made, the likelihood of the child being involved in making decisions increased.

Outcomes and Limitations

Based on the results of the data analysis from the Kentucky Foster Care Census, it seems that this state is doing pretty well regarding meeting the three ASFA well-being outcomes. Outcome 1 related to engagement, services to biological parents, visitation with biological family, and the involvement of the child in their own case decision-making. The mean length of time since the children in the sample had visited with their biological parents was 3.86 months, so it seems that visits are occurring fairly frequently. Almost half of the children (45%) were placed with siblings and had visited with other siblings fairly recently (M = 1.63 months). The CHAID analysis showed that older children were more involved in their case decision-making than were younger children, and that as DCBS visits increased, so did the consistency of the participation.

Also, educational resources (Outcome 2) were being accessed and needs identified for the majority of the children in the sample. Many different people (biological parents, other relatives, foster/adoptive parents, and social workers) were participating in school meetings and signing school documents for the child. Also, school systems seem to be doing a good job of identifying children who need Individualized Educational Plans and getting needed services to these children. Children with an IEP were more likely to be receiving adequate educational and developmental resources.

The mental health and physical health (Outcome 3) needs of the children were being met in a majority of the cases. Most children had been to the doctor and dentist very recently. The percentage of need was the highest related to emotional needs (45%), but 78% of the children in the sample were receiving adequate emotional and medical resources.

One of the limitations of the study was related to instrumentation. Concerns were present regarding the observers and the instrument itself. First, there were 131 census takers that collected data in the study, and they were of different educational levels (both Bachelor's and Master's degree students participated). Although they all received the same mandatory training, it is likely that different census takers interpreted questions in

different ways, perhaps explained items differently, and these differences quite possibly led to changes in the results. In addition, foster parents answered some questions and regional agency staff answered some. Perhaps the other group would have answered differently. It cannot be known who answered which questions on any form, so this is a limitation of the study.

Utility for Social Work Practice

Field of child welfare and social work practice

This study is important to social work practice because it was a unique way to measure child well-being in the child welfare system, by the utilization of a census approach. This research found that this state agency was responsive to children with more needs. It is important to continue these visits and remain vigilant because when the visits are not often enough, the children tend to not get adequate resources in their particular area of need. Children are in care longer probably because they have complex needs (Pecora et al. 2000). They may need a different approach related to their reunification with parents or adoption to remove barriers to permanency. Perhaps a new practice model is needed for complex cases. Having too many unmet needs seems to be a barrier preventing exiting out of the system. However, these data indicate that these children are receiving services for their needs.

There needs to be more focus more on resource-poor communities and look at strategies to develop them. Both urban and rural areas of the state had areas where the resources were not adequate. Education for social workers, foster/adoptive parents and biological parents is important to remind them of what is available and how to get the resources that are needed.

Child welfare research

This study also adds to the literature in child well-being by analyzing results from a well-being study with a census approach, which is an approach not found in the current child welfare and social work literature on child well-being. Perhaps this is because child well-being is a new federal goal for child welfare agencies, so it is expected that more studies of this nature will soon be included in the literature.

The results of the census, overall, showed that the children were receiving a lot of help for their needs. They were being visited fairly frequently by their DCBS workers, receiving educational advocacy, having regular visits to the doctor and dentist, and their needs were being tracked as they continued to be in the system. With the successful completion of the Kentucky Foster Care Census, it seems that this state has begun the process of closing the child welfare pyramid (Altshuler & Gleeson, 1999), by comprehensively studying child well-being, and starting a database that can be utilized for longitudinal studies.

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Table 1
Demographics of Selected Variables

Variable	Descriptive Statistics
Gender	47% male, 53% female
Age	*M* = 8.3, *SD* = 5.57 58% ages 0 – 9; 42% ages 10 – 21
Region, urban vs rural	74% rural, 26% urban
Months in care	*M* = 25.14, *SD* = 27.52
Number of prior placements	*M* = 1.5, *SD* = 2.58
Months spent in current placement	*M* = 18.47, *SD* = 24.32
Enrolled in school	26% no, 74% yes
IEP	70% no, 30% yes
Part of sibling group	19% no, 81% yes
Placed with siblings	45% no, 55% yes
Siblings placed elsewhere	53% no, 47% yes
Months since last sibling visit	*M* = 1.63, *SD* = 5.95
Months time since last biological parent visit	*M* = 3.86, *SD* = 11.758

Table 2
Dependent Variables by Independent Variable Predictors

Dependent Variable	**First Level Predictor (Independent Variable)**
Diagnosed Medical Need 32% yes 68% no	Number of Months in Care X_2 (2, n = 2812) = 38.13, p < .001
Adequacy of Medical Resources/Needs Met 78% yes 22% no	Region X_2 (5, n = 2793) = 186.76, p < .001
Identified Emotional Need 44% yes 56% no	Age X_2 (6, n = 2797) = 419.91, p < .001
Adequacy of Emotional Resources/Needs Met 78% yes 22% no	Region X_2 (5, n = 2959) = 134.85, p < .001
Identified Educational Needs 35% yes 65% no	Individualized Educational Plan X_2 (1, n = 2793) = 849.78, p < .001
Adequacy of Educational Resources/Needs Met 80% yes 20% no	Region X_2 (1, n = 2756) = 137.53, p < .001
Diagnosed Physical Disability 9% yes 91% no	Number of Months in Care X_2 (2, n = 2802) = 29.47, p < .001
Adequacy of the Physical Disability Resources/Needs Met 70% yes 30% no	Region X_2 (5, n = 2794) = 153.85, p < .001
Diagnosed Developmental Disability 23% yes 77% no	Individualized Educational Plan X_2 (2, n = 2797) = 348.80, p < .001
Adequacy of Developmental Disability Resources/Needs Met 74% yes 26% no	Region X_2 (3, n = 2772) = 161.08, p < .001
Child's Involvement in Case Decision-Making	Age X_2 (7, n = 2850) = 1629.26, p < .001